

DEDUCTIBLE REPORT

Michigan Department of Human Services

EACH TIME A MEDICAL EXPENSE IS INCURRED BY A MEMBER OF YOUR FAMILY, COMPLETE ONE LINE OF THIS FORM. GIVE ALL REQUESTED INFORMATION. KEEP COPIES OF BILLS OR RECEIPTS FOR ALL MEDICAL EXPENSES, WE NEED TO SEE THEM.

Grantee Name				
Case Number			Grantee Client ID	
County	District	Section	Unit	Specialist
Date			Other ID (as required)	

DATE OF SERVICE	NAME OF FAMILY MEMBER	CHECK ONE	PROVIDER NAME	PROVIDER ADDRESS	AMOUNT OF CHARGE	TOTAL AMT TO DATE
		<input type="checkbox"/> Doctor Visit <input type="checkbox"/> Prescription <input type="checkbox"/> Other				
		<input type="checkbox"/> Doctor Visit <input type="checkbox"/> Prescription <input type="checkbox"/> Other				
		<input type="checkbox"/> Doctor Visit <input type="checkbox"/> Prescription <input type="checkbox"/> Other				
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When the expenses listed above are more than your deductible amount, return this form to your specialist immediately. You may bring this form and proof of your medical expenses to the office or mail them in. **COMPLETE, SIGN AND DATE PAGE 2 OF THIS FORM BEFORE YOU RETURN IT.**

Specialist		Telephone Number	
County Name		County Address	
County Department of Human Services			
1. List yourself and the name of each family member who lives with you.			
<p>Department of Human Services (DHS) will not discriminate against any individual or group because of race, sex, religion, age, national origin, color, height, weight, marital status, political beliefs or disability. If you need help with reading, writing, hearing, etc., under the Americans with Disabilities Act, you are invited to make your needs known to a DHS office in your area.</p>			

2. Does any family member receive any income from employment or self-employment? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, complete the following:	Total Monthly Earnings Before Deductions	Total Monthly Child Care for Employment Purposes.
Person Working		
	\$	\$
Person Working		
	\$	\$

3. Does any family member pay support or guardianship expenses? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, complete the following:	Total Monthly Support Paid.	Total Monthly Guardianship Expenses Paid..
Person Paying Support/Guardianship Exp.		
	\$	\$
Person Paying Support/Guardianship Exp.		
	\$	\$

4. Other income you have. Include income of all family members. Every item must be completed			
TYPE OF INCOME		MONTHLY AMOUNT	WHOSE INCOME
Social Security Benefits (RSDI)	<input type="checkbox"/> Yes <input type="checkbox"/> No	\$	\$
Supplemental Security Income (SSI)	<input type="checkbox"/> Yes <input type="checkbox"/> No	\$	\$
Retirement or Pension Benefits	<input type="checkbox"/> Yes <input type="checkbox"/> No	\$	\$
Veterans Benefits	<input type="checkbox"/> Yes <input type="checkbox"/> No	\$	\$
Disability Benefits	<input type="checkbox"/> Yes <input type="checkbox"/> No	\$	\$
Rental Income	<input type="checkbox"/> Yes <input type="checkbox"/> No	\$	\$
Workers Compensation	<input type="checkbox"/> Yes <input type="checkbox"/> No	\$	\$
Child Support or Alimony	<input type="checkbox"/> Yes <input type="checkbox"/> No	\$	\$
Unemployment Compensation	<input type="checkbox"/> Yes <input type="checkbox"/> No	\$	\$
Military Allotments	<input type="checkbox"/> Yes <input type="checkbox"/> No	\$	\$
Gambling Distributions (Casino profit sharing)	<input type="checkbox"/> Yes <input type="checkbox"/> No	\$	\$
Other	<input type="checkbox"/> Yes <input type="checkbox"/> No	\$	\$

5. Assets you have. Include assets of all family members. Every item must be completed			
TYPE OF ASSET		VALUE OF ASSET	OWNER OF ASSET
Cash on hand, in a safety deposit box or patient trust fund	<input type="checkbox"/> Yes <input type="checkbox"/> No	\$	\$
Savings, Checking or Credit Union Accounts	<input type="checkbox"/> Yes <input type="checkbox"/> No	\$	\$
Home, life estate, life lease	<input type="checkbox"/> Yes <input type="checkbox"/> No	\$	\$
Real Estate (not your home)	<input type="checkbox"/> Yes <input type="checkbox"/> No	\$	\$
Mortgage, land contract or other notes payable to household member	<input type="checkbox"/> Yes <input type="checkbox"/> No	\$	\$
Savings bonds or money market funds	<input type="checkbox"/> Yes <input type="checkbox"/> No	\$	\$
Stock or mutual funds	<input type="checkbox"/> Yes <input type="checkbox"/> No	\$	\$
IRA, KEOGH, 401K or deferred compensation accounts	<input type="checkbox"/> Yes <input type="checkbox"/> No	\$	\$
Trust Fund(s)	<input type="checkbox"/> Yes <input type="checkbox"/> No	\$	\$
Life Insurance	<input type="checkbox"/> Yes <input type="checkbox"/> No	\$	\$
Annuity	<input type="checkbox"/> Yes <input type="checkbox"/> No	\$	\$
Cars, trucks, boats, motorcycles, other vehicles	<input type="checkbox"/> Yes <input type="checkbox"/> No	\$	\$
Tools & Equipment, Livestock or Crops	<input type="checkbox"/> Yes <input type="checkbox"/> No	\$	\$
Funeral contracts	<input type="checkbox"/> Yes <input type="checkbox"/> No	\$	\$
Burial plot(s), casket, etc.	<input type="checkbox"/> Yes <input type="checkbox"/> No	\$	\$
Certificates of Deposit (C.D.) or savings certificates	<input type="checkbox"/> Yes <input type="checkbox"/> No	\$	\$
Other	<input type="checkbox"/> Yes <input type="checkbox"/> No	\$	\$

I CERTIFY THAT TO THE BEST OF MY KNOWLEDGE, ALL ANSWERS ON THIS FORM ARE TRUE AND COMPLETE.	
Signature	Date
Signature	Date